For office use only
Application number:
Endorsement number:
Issue Date:

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Acupuncture Examiners
P.O. Box 46021
124 Halsey Street, 6th Floor
Newark, New Jersey 07101
(973) 273-8092

Official Application for Acupuncture Endorsement for Physicians

Date: _____

I am currently licensed in the State of New Jersey as a:

- ☐ Medical Doctor
- ☐ Doctor of Osteopathy
- ☐ Dentist

Pursuant to the provisions of New Jersey law at N.J.S.A. 2C-8, licensed physicians, surgeons or dentists may practice acupuncture provided that the course of training of that licensed professional has included acupuncture. Regulations promulgated by the Board of Acupuncture Examiners at N.J.A.C. 13:35-9.16 specify that such training shall include either: graduation from a school approved by the Accreditation Commission of Acupuncture and Oriental Medicine (ACAOM); or the completion of a course of training approved by the Board, consisting of a minimum of 300 hours, at least 150 hours of which shall be clinical training. Physicians or dentists holding this endorsement are prohibited from using the term "Certified Acupuncturist" or "Licensed Acupuncturist." There is no fee associated with this application.

Please print clearly. You must answer all of the questions on this application.

Personal Information

1. Name: _____ (_____)
   First Middle Last Maiden Name

2. Address: _____
   Street City State Zip County

   _____ _____
   Telephone Number E-mail address

3. Date of Birth: _____ Place of Birth: _____
   Month/Day/Year City/State/Country

4. Social Security Number: _____/_____/_____

Privacy Act Notice: You are hereby notified pursuant to the Privacy Act (5 U.S.C. § 552a (note)(b))that disclosure of your Social Security number in this application form is voluntary. The Board of Acupuncture Examiners may use your Social Security number for the following: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Board or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings. Pursuant to N.J.S.A. 2A:17-56.44(e) of the NJ Child Support Enforcement Law and N.J.S.A. 54:50-25 of the NJ Taxation Law, the Board of licensing agency to which this form is submitted is required to obtain your Social Security number and/or federal taxpayer identification number, and where neither is possessed, the reason for not having such a number. The Board is further obligated to provide these identifying numbers to the Director of Taxation and the Probation Division or other agency responsible for child support enforcement.

I _____ ☐consent ☐do not consent to the use of my Social Security number for any of the purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action in inference will be taken or drawn.

5. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are an American citizen, please enclose a copy of your birth certificate or U.S. Passport. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status. Note status here:_____

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

6. Acupuncture Training/Education

_____
Name and address of institution

Date Enrolled _____/_____/_____ ☐ Completed Program on _____/_____/_____

APPLICANTS MUST PROVIDE A TRANSCRIPT FROM AN EDUCATIONAL PROGRAM APPROVED BY ACAOM OR HAVE THE PROGRAM SPONSOR COMPLETE THE ATTACHED EDUCATION VERIFICATION FORM. THIS MATERIAL SHOULD BE FORWARDED DIRECTLY TO THE BOARD OFFICE.

7.. Do you currently hold, or have you ever held a professional license of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

If you have answered "Yes" to question #7please indicate the state(s) below.

State that issued the license	***License Number***	***Date issued/expired***	***Status***

All questions must be answered

9. Have you ever been arrested, charged with and/or been convicted of any crimes or offenses (including petty offenses) as an adult or juvenile, excluding motor vehicles offenses, except driving while intoxicated? ☐ YES ☐ NO

10. Have you ever been convicted of any crime or offense under any circumstances such as, but not limited to, a plea of guilty, Non Vult, Nolo Contendere, No Contest, etc., or a finding of judge or jury? ☐ YES ☐ NO

11. Have you ever been denied a license to practice a profession or eligibility to sit for a licensing exam in this state, any other state, or foreign country, or have you been permitted to withdraw an application for licensure while under investigation? ☐ YES ☐ NO

12. Have you ever been the defendant in a malpractice suit? ☐ YES ☐ NO

a. Have you ever been denied malpractice insurance coverage? ☐ YES ☐ NO
b. Have you ever had any practice curtailments? ☐ YES ☐ NO
c. Have you ever been assessed a surcharge? ☐ YES ☐ NO
d. Has limitation ever been required? ☐ YES ☐ NO
e. Have you ever been required to have office monitoring? ☐ YES ☐ NO

13. Is there any action pending against you now, or in the past, whether for a crime of offense or any action by a regulatory agency, such as but not limited to professional licensing agencies, Medicaid, Medicare or any other government agency? ☐ YES ☐ NO

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS, #9 THROUGH #13, YOU MUST PROVIDE THE FOLLOWING:

- ***A WRITTEN EXPLANATION OF THE INCIDENT.***
- ***COURT OR AGENCY RECORDS***

FOR THE PURPOSES OF THE FOLLOWING QUESTIONS, #14 THROUGH #19, THE FOLLOWING PHRASES OR WORDS HAVE THE FOLLOWING MEANINGS:

Ability to practice acupuncture is to be construed to include all of the following:

A. The cognitive capacity to make an appropriate acupuncture clinical diagnoses, exercise reasoned acupuncture judgments and to learn and keep abreast of acupuncture developments; and

B. The ability to communicate those judgments and acupuncture information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

C. The physical capability to perform acupuncture tasks such a physical examination and acupuncture procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"***Medical condition***" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"***Chemical substances***" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"***Currently***" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"***Illegal use of controlled dangerous substances***" means the use of controlled dangerous substances obtained illegally (i.e. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

You have a right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure will be processed if you claim the Fifth Amendment privilege against self incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question which you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. N.J.S.A. 45:1-20.

14. Do you have a medical condition which in any way impairs or limits your ability to practice acupuncture with reasonable skill and safety? ☐Yes ☐No If yes, please explain.

_____

_____

15. Does your use of chemical substance(s) in any way impair or limit your ability to practice acupuncture with reasonable skill and safety? ☐Yes ☐No ☐Not Applicable If yes, please explain.

_____

_____

16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?

☐Yes ☐No ☐Not Applicable If yes, please explain.

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for physician endorsement.

_____

_____

17. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?

☐Yes ☐No ☐Not Applicable If yes, please explain.

_____

_____

18. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?

☐Yes ☐No If yes, please explain.

_____

_____

19. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐Yes ☐No

If you answered "Yes" to question 19 are you currently participating, or have you within the past two (2) years participated, in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?

_____

_____

AUTHORIZATION

I _____, hereby authorize all hospitals*, institutions* or organizations, my references, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the New Jersey State Board of Acupuncture Examiners any information, files or records requested by the Board. I further authorize the New Jersey State Board of Acupuncture Examiners to release to the organizations, individuals and groups listed above any information.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind, and I declare under penalty or perjury that my answers and all statements made by me herein are true and correct and further declare that I am the person referred to in the above application. Should I furnish any false information in this application, I hereby agree that such an act shall constitute cause for denial, suspension or revocation of my physician endorsement to practice acupuncture in the State of New Jersey.

I HAVE READ THE ABOVE
AND UNDERSTAND SAME

_____ _____
Applicant's Name (Please Print or type) Date

_____
Signature of applicant

Affix Seal Here

Sworn to before me this _____

day of _____ , 20_____

_____
Notary Public

- relating to clinical or post-graduate programs

If you require additional space on which to answer any of the preceding questions you may attach your response to the last page of this application, having made sure that you print or type your name to each attachment.

CHILD SUPPORT

Please certify under penalty of perjury, the following questions:

20.	Do you currently have a child-support obligation?	☐ YES	☐ NO
	If yes, are you in arrears in payment of said obligation?	☐ YES	☐ NO
	If yes, does the arrears match or exceed the total amount payable for the past six months?	☐ YES	☐ NO
21.	Have you failed to provide any court ordered health insurance coverage during the past six months?	☐ YES	☐ NO
22.	Have you failed to respond to a subpoena relating to either a paternity or child supporting proceeding?	☐ YES	☐ NO
23.	**A**re you the subject of a child support related warrant?	☐ YES	☐ NO

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions 20 through 23 will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____ _____

Applicant's Name (Please Print or type) Date

_____

Signature of applicant

Affix Seal Here

Sworn to before me this _____

day of _____ , 20_____

_____

Notary Public

Official Use Only
☐ Dual License
License Type 1

Applicant's Number

License Type 2

Applicant's Number

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
Acupuncture Examining Board
P.O. Box 46019
Newark, New Jersey 07101
(973) 273-8092

Official Use Only
☐ Resubmit

Board or Committee

Certification and Authorization Form For a Criminal History Background Check

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____/_____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs**, you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. The fee for this background check will be $28.25. Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

Continuation on the reverse side ➡

Certification

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

New Jersey Office of the Attorney General
Division of Consumer Affairs
New Jersey State Board of Acupuncture Examiners
124 Halsey Street, 6th Floor, P.O. Box 46021
Newark, New Jersey 07101
(973) 273-8092

Verification of Acupuncture Education

Name of Applicant: _____
First Middle Last

Course Provider: _____

Course title: _____

Location: _____

Hours completed:_____

Number of didactic hours:_____

Number of clinical hours:_____

Were any negative reports filed by instructors regarding this individual? Yes_____ No_____

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for physician endorsement to practice acupuncture.

_____

_____

Dates of enrollment: From _____To_____

It is hereby certified that the above named physician or dentist has successfully completed the educational program described above. This individual received full credit from this organization for the course shown.

_____
Signature Print Name Title

Date:_____ (Seal of Orgnaization)